July 16, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1146-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient had an MRI of the cervical spine performed on 3/3/03, and it revealed obscuration at the level of C4/5 and C5/6 due to postoperative metallic artifact and as well demonstrated a posterior osteophyte decreasing the spinal canal to a diameter of 9 mm at the level of C3/4, and also a large central herniated disc that came into contact with the anterior aspect of the spinal cord at the level of C6/7, as well as a C7-T1 right lateral herniated disc that caused neural foraminal stenosis. The patient complains of pain in the neck radiating to the right shoulder and into her upper extremities. On 2/27/03 she was noted to have weakness of the biceps bilaterally. On 3/7/03 she was found to have findings consistent with cervical myelopathy. She was recommended to undergo 360-degree cervical decompression and fusion.

REQUESTED SERVICE

Cervical anterior vertebrectomy and fusion with instrumentation at C3/4 and C6/7 with posterior cervical laminectomy at C3 through C7 with arthrodesis and instrumentation is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The cervical anterior vertebrectomy and fusion with instrumentation at C3/4 and C6/7 with posterior cervical laminectomy at C3 through C7 with arthrodesis and instrumentation is medically necessary for this patient.

Treatment guidelines and care standards indicate that cervical spinal stenosis such as ___ suffers, due to a combination of spondylotic disease, congenital narrowing and disc herniation in a patient who is already status post-prior-anterior cervical decompression with residual spinal stenosis is best dealt with by 360˚ cervical decompression and fusion, as is requested for this patient.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 16th day of July 2003.